THE PATIENT CENTERED MEDICAL HOME

Terry McGeeney MD, MBA
President/CEO of TransforMED

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A wholly-owned subsidiary of the American Academy of Family Physicians –a 501c6 organization

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YOU KNOW EXACTLY WHAT YOU ARE GETTING

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YOU HAVE NO IDEA WHAT YOU ARE GETTING

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THIS IS A CHALLENGE TO BE ADDRESSED BEFORE THE PILOT EVER GETS STARTED

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WHY DO SOME THINK THE TRAIN IS COMING OFF THE TRACKS?

- Blurred identity
- Political issues
- Patient acceptance and understanding
- Physician understanding
- Over-sold/Over-Hyped
- Lack of metrics of success—has to be more than about money

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PATIENT CENTERED MEDICAL HOME HAS LOST ITS IDENTITY DUE TO POOR DEFINITION

- Chronic Disease Management
- Pay for Performance
- Health Information Technology
- Partial PCMH
- Practice Centric not Patient Centric
- Payer is the winner not the patient

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POLITICAL ISSUES

- Comprehensive Care
- Whole person orientation
- The pie is not going to get any bigger

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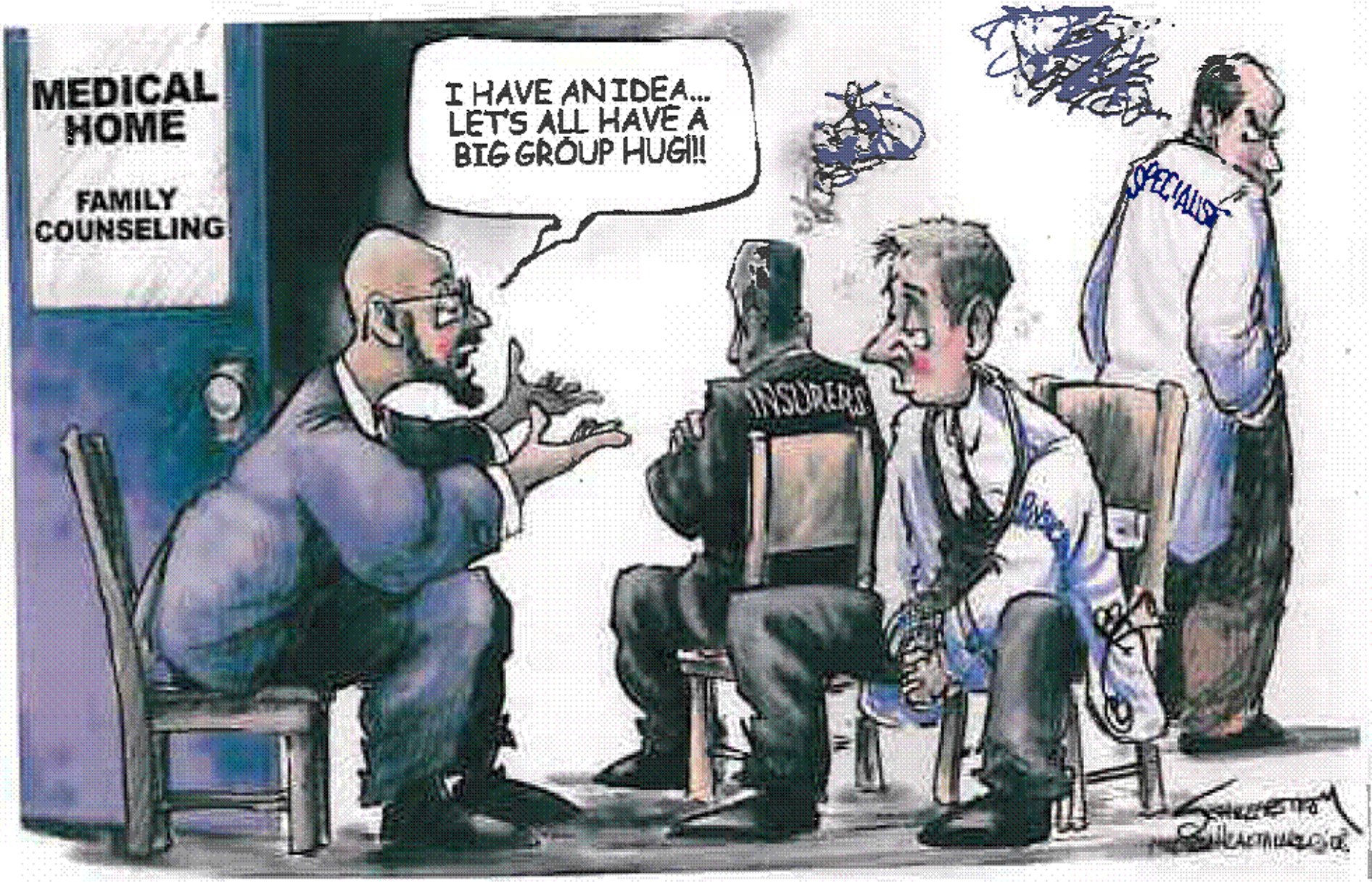

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PATIENT ACCEPTANCE AND UNDERSTANDING

- Patients have never liked the term
- Lack of understanding
- Perceived similarity to managed care

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Physician Understanding

50 Reasons Not To Change

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OVER-HYPED AND OVER-SOLD

- No Clear PCMH Definition
- No accurate PCMH standards
- No complete way to measure “medical homeness”
- The latest “latest and greatest”, “best thing since sliced bread”

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LACK OF METRICS OF SUCCESS

- Has to be about more than money
- Have to be based on complete medical homes—partial medical homes lead to partial or no success
- Outcomes

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The Patient Centered Medical Home

- The Patient Centered Medical Home creates a **framework** for change
- The Patient Centered Medical Home creates a common **language** for change
- The Patient Centered Medical Home creates an **opportunity** for change

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THINK OF MEDICAL HOME IN THE CONTEXT OF A MEDICAL VILLAGE

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THE "MEDICAL VILLAGE"

- Collaborative Care
- Coordinated Care
- Shared Responsibilities
- Community Resources
- Team Care in and outside the practice
- Interoperable Technology
- Shared vision/alignment
- Education

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PATIENT CENTERED MEDICAL HOME

It cannot be about the name, but about the content and value

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IT'S ABOUT A PATIENT CENTERED MODEL OF CARE

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The TransforMED Patient-Centered Model

A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Access to Care & Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Lab results highly accessible
- Online patient services
- e-Visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice Services
- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Care coordination
- Patient engagement and education
- Leverages automated technologies

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Continuity of Care Services
- Community-based services
- Collaborative relationships
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

TransforMED Demonstration Practice Locations

Source: American Academy of Family Physicians

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WHAT WAS LEARNED

- Some practice can do well with strong leadership and focus
- Many practices need help and support
- Most practices think they are doing better and more than they are
- Some practices already are Patient Centered Medical Homes
- PCMH is often viewed as more complex than it really is

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Challenges Identified from the NDP

- Primary care practices are not prepared to change
- Primary care practices are not motivated to change
- Primary care practices are woefully uninformed
- Leadership at the practice level is lacking particularly around transformation
- Communication within a practice is a major limiting factor for success
- E-visits are not well accepted by patients
- Access and cost are of primary importance to patients — they assume quality; EMR and efficiency are “back hall” issues.
- Chronic care is poorly understood by patients and providers
- Registries are critically important for chronic care, but practices are unwilling or unable to do manual entry of data---registries must be self populating and must be associated with the ability to store and transmit data

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Challenges Identified from the NDP

- The biggest concern about technology implementation is operational not cost
- Most practices think they are providing quality care but most are not
- Safety at the practice level is inadequate
- Understanding and expertise on business issues is sorely lacking
- Practice ownership, particularly by hospitals, limits medical home implementation
- Providers in a practice have lost skills, refer too easily and lack confidence in procedures
- Advanced access scheduling is poorly understood and thus often poorly implemented
- Team care is a difficult concept for Family Physicians to grasp
- The larger the practice, the harder it is to transform
- Doing “things” to check boxe does not create a patient centered environment and may actually make the practice worse

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What are the NDP Positives?

- Population based registries work and are a critical success factor for chronic disease management and patient centered care
- Quality outcome metrics modify behavior
- Team concepts really do work and lead to higher quality, greater productivity and improved job satisfaction by providers and staff
- Practices can do well financially in today's payer environment when operated as a business
- Practice Web sites are popular with practices and patients
- E-visits work but patients need to be better educated and incentives need to change for patients and providers

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What are the NDP Positives?

- Patients and providers like group visits
- Advanced access scheduling really works
- The entire model of care can be implemented
- Point of care evidence based reminders improve quality and provider satisfaction
- The critical success factors for EMR implementation are change management and planning. It does not have to be traumatic
- The components of the new model are interdependent

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FOUR CRITICAL SUCCESS FACTORS

- Teamwork
- Change Management
- Leadership
- Communication

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Change is not pleasant!

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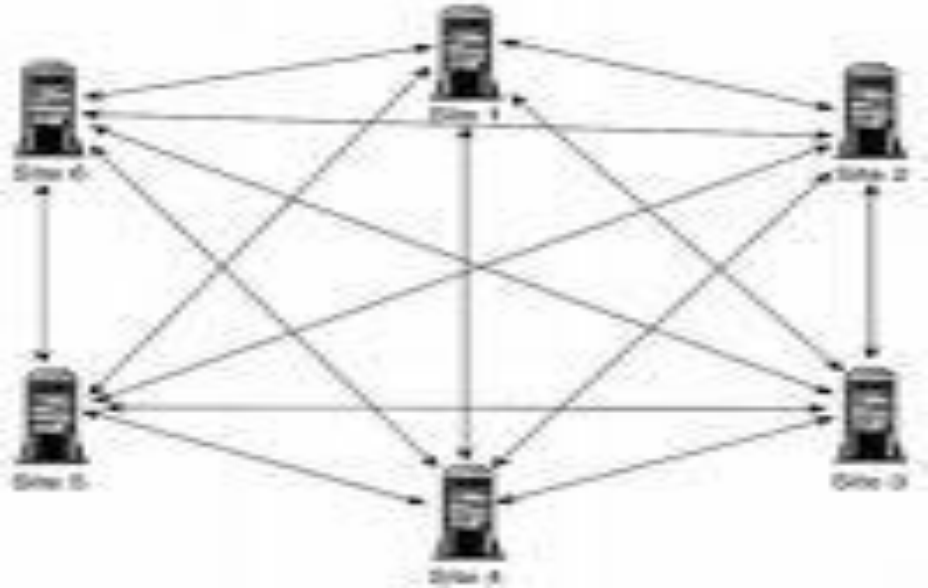
Change is not an isolated event

Change in one area will create change in another area.



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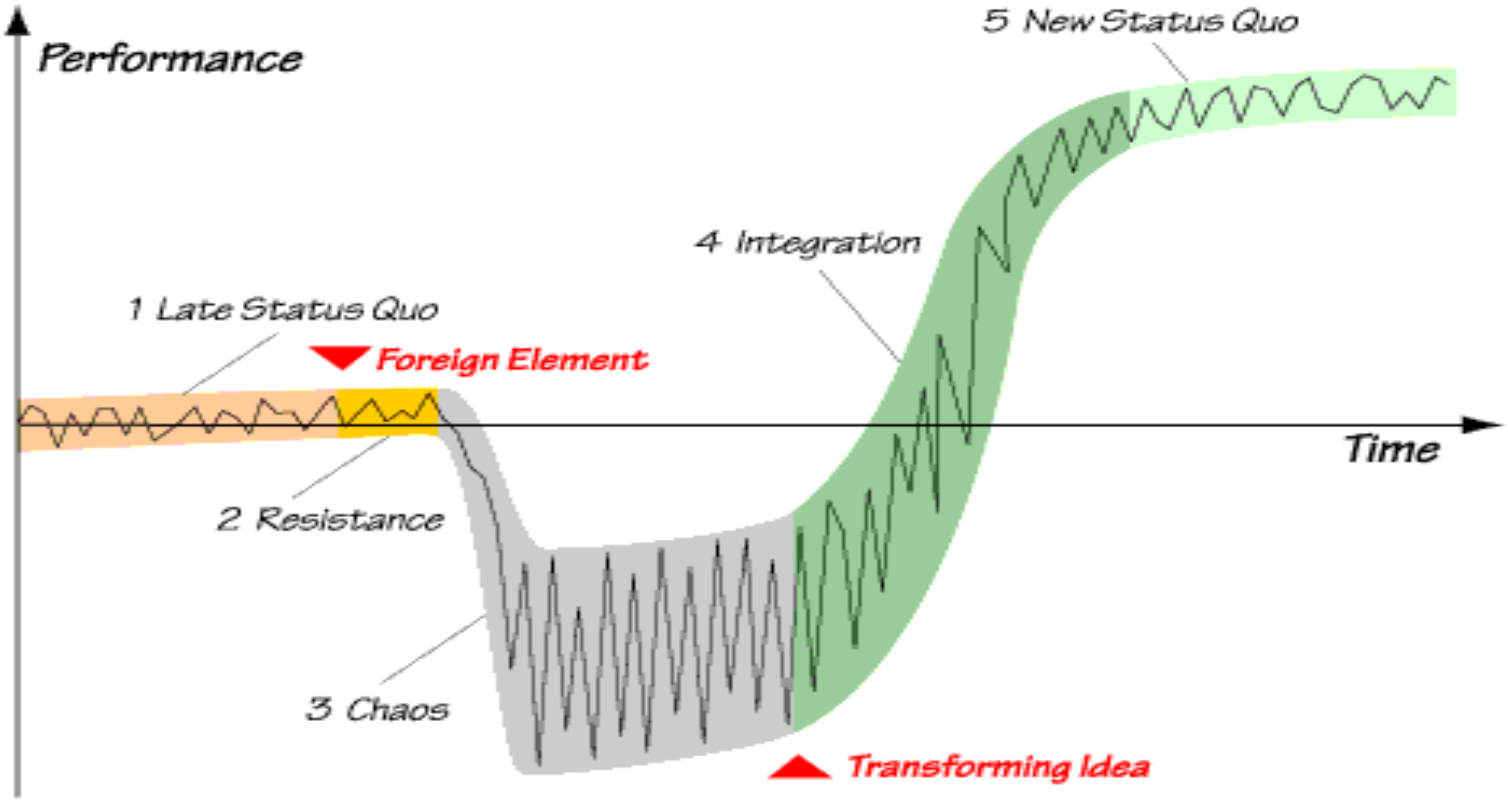
Chaos is part of the process

- 

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VALUE OF A PROJECT OR PILOT

- Creates a focus and vision
- Provides support, leadership and resources
- Often creates an opportunity for realignment of incentives
- Creates market visibility and positioning
- Takes the next step further demonstrating improved outcomes around quality and efficiency

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PAYER PILOTS

- The next step after the NDP
- Testing of payment methadologies
- Documentation of efficiency
- Documentation of improved outcomes based on practice data

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Payment Methodologies

- Pilot Payment Methods
- **Global Payments**
- **Shared Savings Concept**

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PRACTICE PAYMENT METHODS

- **Enhanced FFS** (Fee for Service)
- Enhanced FFS +P4P (outcomes based)
- Enhanced FFS + Care Management Fee (CMF)
- Enhanced FFS + CMF + incentives (outcomes = quality and efficiency (cost savings) and PCMH recognition)
- **CMF** (care management fee)+ incentives
- CMF + incentives + grants
- CMF + incentives + shared savings
- **Capitation, no-risk** + incentives
- Capitation, no risk with FFS carve outs for procedures and incentives

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SHARED SAVINGS MODEL

- Downward pressure on hospital days
- Concept is too share savings from reduced hospital days and other costs with referring physicians
- Opportunity for “hospital at home” concept
- Component of CMS pilot and some Medicare advantage projects

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MULTI-PAYER PILOT CHALLENGES

Agreement on a payment methodology

Keeping the practice “whole”

Risk adjustment

Capturing real-time practice and payer data

Data repository

Agreement on practice metrics

Shared vision and alignment around a model of patient centered care

Sustainability

Support at the practice level

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IDEAL MULTI-PAYER MODEL

- Shared learning environment—Collaborative meetings/Symposiums, on-line learning community
- Practice level support—in person or virtual over all aspects of PCMH not just chronic disease management
- Shared self-populating registry and data repository
- Aligned incentives—financial and work flow (paperwork reduction)

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TRANSFORMING MEDICAL PRACTICES

SEARCH Google™ Custom Search

What does your Medical Home look like?

TMED MHIQ

CLICK HERE TO FIND OUT

MEDICAL HOME IMPLEMENTATION QUOTIENT ONLINE SELF-ASSESSMENT

Join TransforMED at a special 10/19 pre-conference session at National Healthcare Incentives Institute in Washington, DC

On the afternoon of Sunday, September 19, 2008, the National Healthcare Incentives Institute presents a pre-conference session featuring PCMH thought leaders from TransforMED. The purpose of the National Healthcare Incentives Institute is to convene national and international experts on healthcare incentives and to share innovative initiatives and practical case studies. This year the Healthcare Incentives Institute is collocated with the Consumer Driven Healthcare Summit; one registration permits attendance at both conferences. **Click here to find out more about TransforMED's presentation agenda and the HII event.**

Report from the CEO:
PCMH Movement Requires Real Transformation

"Economist Joseph Antos was quoted in a **cover story in the July 13 edition of USA Today** as saying that the Patient Centered Medical Home (PCMH) movement needs to be more than just rearranging the deck chairs on the Titanic or an excuse to spend more money. I could not agree with him more."

TransforMED is transforming the practice of Primary Care

AAFP

TransforMED is focused on practice redesign and affiliated with the American Academy of Family Physicians (AAFP). TransforMED is studying and implementing transformed models of high performance practices that meet the needs of both patients and practices. **More about TransforMED**

In June 2006, TransforMED launched a 24-month National Demonstration Project (NDP), serving as a "learning lab" to generate new knowledge about the process of practice transformation and to systematically evaluate and compare the effect of two practice transformation approaches on practice and patient outcomes. **Visit the Learning Labs** and meet the **participating practices**

As results and insights emerge, TransforMED professional staff are using the lessons learned from the NDP to develop services, collaboration tools and learning opportunities that empower physicians and primary care practices across the country as they implement the TransforMED Medical Home Model. **What's a Transformed Practice?**

p^4

TransforMED also coordinates a residency demonstration initiative known as P^4 – P to the fourth power – which stands for Preparing the Personal Physician for Practice. The P^4 residency demonstration initiative evaluates and supports

Thank You!

Terry McGeeney MD

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